The notion of cooperation across political jurisdictions is not a new concept, especially in a state like Kansas. Long have local leaders looked across borders to solve challenges and address changing needs. The field of public health is no different.

For years, almost all local health departments have engaged in regional cooperation for bioterrorism preparedness. Given changing realities (decreased financial support from higher levels of government, increased standards of service expectation via assessments such as accreditation, and so forth), it has become important to examine the notion of regional cooperation for public health on a broader scale. (See Figure 1 on page 3 for the current public health regional map.)

Why regional cooperation? Because the rural nature of Kansas makes it cost prohibitive for every county to single-handedly meet the financial burden associated with the minimum expected service level in public health, and such cooperation offers an avenue through the fiscal hurdles without resulting in full-fledged consolidation of departments.
Welcome to the Kansas Association of Counties/Kansas Association of Local Health Departments (KAC/KALHD) Research Report on Public Health Regional Cooperation. This is a layman’s guide on the Kansas model of regional cooperation (a model used for years in bioterrorism preparedness), which offers a realistic avenue for any local health department to meet service expectations (such as those tied to public health accreditation).

The report will focus on three key areas:

1. The legal aspects of the regional cooperation model;
2. The funding aspects of the regional cooperation model; and
3. The multi-jurisdiction model envisioned to achieve public health accreditation.

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GLOSSARY

HIPAA: Health Insurance Portability and Accountability Act

Interlocal Agreement: A signed agreement between multiple counties. It requires approval from the Kansas Attorney General to become binding (K.S.A. 12-2901 et seq.).

NACCHO: National Association of County and City Health Officials

PHAB: Public Health Accreditation Board, the accrediting body for national public health accreditation.

Regional Cooperation: Formalized agreements between governments to work together to provide a service. Regional cooperation is a functional form of regionalization, meaning that operationally the benefits of cooperation are realized without a loss of political autonomy for each county’s department involved in the effort.
The Legal Aspects of the Regional Cooperation Model

KALHD has worked extensively with attorney Martie Ross (with law firm Spencer Fane Britt & Browne LLP) regarding the legal specifics necessary to make the regional cooperation model operational. Fundamentally, all the necessary ingredients are represented in an interlocal agreement. These agreements are approved by all the county commissions participating in the region. After that, the agreement requires approval from the Kansas Attorney General. If approved, the agreement goes into effect and the region is operational.

So, what is in such an interlocal agreement? Here are highlights from the “Interlocal Agreement for Public Health Regional Collaboration” provided by attorney Ross:

1. The purpose of the region must be defined. For public health, this means the Ten Essential Public Health Services (see Figure 2 on page 4). The interlocal agreement identifies those services that will be provided regionally, such as those that were initiated in response to emergency preparedness. It is expected that some of the Ten Essential Public Health Services will be provided by the region as a whole, and some will continue to be provided by individual counties. The scope of the regional services covered within the agreement is a matter that needs to be developed by the counties participating in the region.

2. The region must be granted authority. This means it can set a budget, be sued, hold property, and establish procedures.

3. The region has its own board of directors.

4. The region’s board of directors will establish strategic and operational plans. It will also be responsible for reviewing and updating those plans as time goes by.

5. The region’s board will help its affiliated agencies with public health accreditation.

*Ellis County and Rush County are not in public health regions*
(This will be discussed in more depth later.)

(6) The region’s board will implement the necessary steps to comply with HIPAA privacy and security requirements, as necessary. (Local health departments already have policies and procedures in place to comply with HIPAA requirements.)

(7) The region shall have an operating account.

(8) Agency contributions to the region shall be established to define how much participating counties will contribute.

(9) Financial reports are due from participating agencies to the region, showing their support levels to the region. Likewise, the region shall give participating agencies a report of its own financial information.

(10) Participating agencies shall provide personnel to work with the region if the region requests it.

(11) The region can also request use of an agency’s real and personal property.

Beyond the highlighted elements, the interlocal agreements also clarify liability, how agencies can leave the region, dispute resolution, and how the region can continue on if membership changes. A copy of the “Interlocal Agreement for Public Health Regional Collaboration” is available online: http://www.kalhd.org/attachments/wysiwyg/5/ModelInterlocalAgreement.pdf

The Funding Aspects of the Regional Cooperation Model

The regions formed via interlocal agreements need resources in order to conduct their regional services. As per the interlocal template, agreed-upon agency contributions are designed to meet the start-up

| 1. | Monitor health status to identify and solve community health problems. |
| 2. | Diagnose and investigate health problems and health hazards in the community. |
| 3. | Inform, educate, and empower people about health issues. |
| 4. | Mobilize community partnerships and action to identify and solve health problems. |
| 5. | Develop policies and plans that support individual and community health efforts. |
| 6. | Enforce laws and regulations that protect health and ensure safety. |
| 7. | Link people to needed personal health services and assure the provision of health care when otherwise unavailable. |
| 8. | Assure competent public and personal health care workforce. |
| 9. | Evaluate effectiveness, accessibility, and quality of personal and population-based health services. |
| 10. | Research for new insights and innovative solutions to health problems. |

funding needs of the region. Historically, the existing public health regions have been funded with Preparedness Funding (i.e., regional grants). As the scope of regional services expands beyond preparedness, the funding mechanism will need to change.

Beyond that, how a region is funded depends greatly on how it operates. If participating agencies feel the region could better serve in a role that was locally funded by all the agencies in the past, then annual contributions for the service could be warranted. One example of this sort of action would be disease investigation. Participating counties may decide that pooling their investigation funds at the regional level and having a regional investigator may be more cost effective than providing the service county-by-county.

However, nothing prohibits a region from generating its own funding independent of ongoing county support. Donations are one possibility, but a more likely source would be grant funding. There are a lot of grants in the public health field, many from the federal government and many from private foundations. A lot of these grants are competitive, meaning that health departments compete with one another in trying to secure the funding. Small health departments are typically at a disadvantage when it comes to competitive grants, for two main reasons:

1. The small department often lacks access to a grant writer who understands the best way to craft a proposal for a competitive grant; and

2. Many grants prioritize where the biggest impact will be felt. This often means a bias for larger populations than many rural counties possess.

A region expands the geographic and population coverage area, making the grant application more attractive. Also, many grants also prioritize inter-jurisdictional cooperation grants above solo-entity grants, thus giving another advantage to a regional submission. Coupled with the possibility that regions are better able to have access to professional grant writers, it is quite conceivable that a region could bring substantial funding outside of local tax support.

The Multi-Jurisdiction Model Envisioned to Achieve Public Health Accreditation

Perhaps the most talked-about concern nationally regarding health departments these days involves accreditation. The Public Health Accreditation Board (PHAB) has been working on the accreditation standards for quite some time, and has beta-tested the application process on a national level. Kansas has been directly involved with PHAB in a variety of ways, not the least of which being discussions regarding multi-jurisdictional accreditation.

Within the PHAB accreditation process, there are three types of applications:

1. Local Health Department Application

2. Regional Application: Fits with a consolidated model of regionalization.

3. Multi-Jurisdictional Application: This conforms most closely with the Regional Cooperation Model used in Kansas under the Interlocal Agreement Act.

Kansas has been actively working with national partners, including PHAB and the National Association of County and City Health Officials (NACCHO), in proposing how a multi-jurisdictional application would work. A significant aspect of this multi-jurisdictional application process is for the region to determine which services/accreditation requirements will be provided by the local health departments in the region and which services will be provided through the regional cooperation. This delineation is
not predetermined, but decided by the participating counties on what will be done at the regional level.

The multi-jurisdictional approach proposed to PHAB relies on the following:

(1) The region has an interlocal agreement;

(2) The region designates a local health agency member to be the one to initiate the application process for the region;

(3) All participating departments would have to be ready for the accreditation review at the same time. There would just be one orientation, readiness checklist, statement of intent, and accreditation process training; and

(4) PHAB prerequisites are met (described in their Guide to National Voluntary Accreditation).

Given that the documentation of regional services would represent all the participating departments, it would only need to be submitted once. This should result in a savings of time versus if each department filed for accreditation on its own. In turn, this should result in a reduction in application costs, since PHAB’s time investment is also reduced for the review.

For the self-assessment tool, the regional documents should be centralized at one member’s department (electronic storage is assumed, as all PHAB documentation requirements are compiled and submitted electronically), and a website to help the departments coordinate these efforts is ideal. PHAB will need to develop an application module for the details of this process (it does not exist at this time). KALHD has recommended working with the East Central Region to develop a web-based system for storing documents during the preparation work before filing for accreditation. *(See Figure 1, page 3, “EC Coalition” for counties represented by the East Central Region.)* KALHD asked that unspent money from the Regional Accreditation Grant funded by the Kansas Health Foundation be used for this purpose.

The East Central Region received funding from NACCHO to conduct a Regional Community Health Assessment. One of the grant requirements is that the grantee will file for accreditation by the end of 2012. The East Central Region has indicated their interest in working with KALHD in developing this sort of documentation system to support a multi-jurisdictional application. This system may be of interest to applicants to use in the pre-filing months of preparation.

In terms of the site visit step of accreditation, some PHAB measures will be demonstrated at the regional level and some at the local level (which depends entirely on the region and what it chose to handle across jurisdictions). The multi-jurisdictional measures are assessed one time, and if they pass, all participating counties would be recognized as being compliant on those measures. Any measures not demonstrated by a department collectively would be required individually, as they normally would be in a single-agency application.

The important thing to note is that despite the application being multi-jurisdictional, accreditation is still department specific. This means if a department leaves a region, the rest of the region’s members are not impacted in their accreditation status. Departments that do not meet the local component requirements during a region’s review do not jeopardize the accreditation of the others, and can apply individually at a later date to obtain accreditation, or wait for the region to file a multi-jurisdiction renewal and attempt to obtain accreditation at that time.

\footnote{Snethen, E., Pezzino, G., & Miyahara, B. (2010). Proposal for the implementation of a multi-jurisdictional accreditation process: A report to the Public Health Accreditation Board, Topeka.}
The Kansas Association of Local Health Departments (KALHD) is dedicated to strengthening local health departments for the purpose of improving and protecting the health of all Kansans. For more information about KALHD, please visit our website at http://www.kalhd.org/

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